STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. BUILDING 00 B. WING	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE	3401 SOLDIERS HOME ROAD WEST LAFAYETTE, IN47906

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F0000	This visit was for the investigation of complaint number IN00092997. Complaint number IN00092997: Substantiated, Federal/State deficiencies related to the allegations are cited at F441 Dates of survey: July 8, 11, 12 and 14, 2011 Facility number: 000271 Provider number: 155402 AIM number: 100291260 Survey team: Vanda Phelps, RN Census bed type: SNF/NF 74 Total 74 Census payor type: Medicare 14 Medicaid 55 Other 5 Total 74 Sample: 3 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/19/11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0441 SS=E	Cathy Emswiller RN The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure residents personal items were stored in a hygienic manner for 3 of 3 residents in	F0441	**F441**It is the policy of this facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable	07/27/2011

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	the sample of 3 reviewed for a hygienic environment. (Residents M, Q and S) Findings include: 1. Resident Q's clinical record was reviewed on 7/11/11 at 12:40 p.m. Her diagnoses included, but were not limited to, persistent vegetative state, "yeast infection," and "infection." She was observed lying in bed during the orientation tour of 7/8/11 at 1:45 p.m. being fed through a feeding tube. Her 6/2/11 annual Resident Assessment Instrument indicated she was dependent on staff for all aspects of her care. On 7/3/11 she was diagnosed with an abscess of her left jaw just beneath her ear for which the physician had ordered an antibiotic. She had chronic skin areas diagnosed as a yeast infection. They were around the feeding tube site, and in multiple skin folds. At 3:30 p.m. on 7/11/11, Resident Q's bedside stand was observed with the Director of Nursing present. In 3 of 3 drawers, clothing, care items and trash were commingled. Examples follow: drawer #1 contained: A. an unattached cord which appeared to belong to something electronic B. plastic bags of the sort hands-on staff		environment to help prevent transmission of disease and infection.**I. Affected by Alleged Practice**Residents Q, S, and M had no adverse reaction. The identified drawers were immediately cleaned, organized, and potentially contaminated material was removed on 7/8 and 7/11.**II. Potential to be Affected**Each resident has the potential to be affected. A 100% audit was immediately completed on 7/12/11 to ensure that each resident's drawers were organized, clean, and did not contain any potentially harmful material. All personal belongings and nursing supplies were placed in plastic bags to prevent the commingling of supplies and personal belongings. The Staff Development Coordinator has in-serviced staff 7/15 and 7/18 in regards to our infection control program to ensure a safe, sanitary, and comfortable environment is maintained to help prevent the development and transmission of disease and infection.**III. Systemic Changes**All C.N.A.'s and staff have been in-serviced by the Staff Development Coordinator on 7/15 and 7/18, including c.n.a # 3 and #4, in regards to maintaining well organized/clean drawers and our infection control program to ensure a safe, sanitary, and comfortable environment is maintained to help prevent the development and transmission of	

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	use for soiled linens C. a washcloth D. an activity apron or blanket with multiple pockets which was crumpled and stuffed into the drawer E. an unopened feeding tube flush kit F. an uncapped tube of dry skin ointment G. unfolded personal clothing commingled with CDs H. an blade razor which was not capped drawer #2 contained: A. two empty toothette bags B. a toothette in a mesh bag--the toothette was uncovered C. crumpled items of personal clothing drawer #3 contained: A. a box of bandages for the feeding tube site B. a splint C. washcloths scattered among the other items D. two small stuffed animals E. Avand brand gauze F. an unlabeled spray bottle marked with the resident's name which contained about one ounce of liquid in it 2. During the orientation tour, Resident S was observed lying in bed. The Director of Nursing indicated during that time, the Resident currently had a urinary tract infection. Her chest of drawers was		disease and infection. In addition, Nursing management will monitor drawer's cleanliness daily when making rounds. Residents who have had an issue with hoarding have been educated, care plans and care guides have been adjusted as well to ensure a safe, sanitary environment will be maintained. **IV. Method to Monitor** The Infection Control Nurse/designee will review three rooms daily Monday-Friday for the next 90 days to ensure drawers are well organized, clean, and do not contain any potentially harmful material. findings will be logged daily Mon. -Friday and submitted to the Executive Director for review.The Housekeeping Supervisor and or designee will check three rooms daily Monday-Friday for the next 90 days to ensure drawers are well organized, clean, and do not contain any potentially harmful material. All findings will be logged daily Mon-Friday and submitted to the Executive Director for review.Findings will be brought to performance improvement for 90 days to ensure 100% compliance. Findings will be analyzed and trends identified with an action plan to resolve any issues noted.**V. Completion Date 7/27/11**We would like to respectfully request paper compliance.	

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	also observed 7/8/11 during the 3:30 p.m. observation tour. drawer #1 contained: A. a box of wipes for incontinence care B. baby oil C. gauze dressing (Kerlix) unrolled, knotted and woven throughout the contents of the drawer it appeared soiled and yellowed, but not necessarily used D. a bag of plastic spoons E. a box of envelopes F. Kleenex packets G. empty packaging for gauze dressings H. TED hose I. unmatched socks J. Christmas Santas K. spools of thread in a baggie drawer #2 contained: A. a roll of toilet paper B. personal night clothes C. fake flowers drawer #3 contained: A. a portable lap top B. Christmas cards C. container of coffee D. phone book 3. During the orientation tour, Resident M was identified as having a recent history of a urinary tract infection. Her			

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	bedside stand was observed 7/8/11 during the 3:30 p.m. observation tour. drawer #1 contained: A. 2 open, partially eaten bags of Cheez-Its B. a can of cookies C. a Bible D. soiled panties drawer #2 contained: A. wipes B. a stuffed bear and rabbit C. incontinence pads drawer #3 contained: A. a box of yellowed 4 X 4 dressings Resident M's chest of drawers was also observed. drawer #1 contained: A. tube of perineal cream B. socks which were loose in the drawer, i.e. not paired drawer #2 contained: A. unfolded personal clothing B. a checkbook with blank checks C. an uncapped razor D. received mail E. Loreal tangle tamer F. a spiral notebook drawer #3 contained: A. a pen			

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	B. batteries loose in the drawer C. an emesis basin D. scarves E. playing cards 4. The dresser which belonged to an unoccupied bed was observed as well. drawer #1 contained: A. two partial bags of Prevail underwear (incontinence product) B. apricot body wash drawer #3 contained: A. a crumpled shawl 5. The Director of Nursing indicated during this tour that she was displeased with the condition of these drawers and would be doing inservices immediately to correct the situation. 6. A family member for resident P was interviewed on 7/8/11 at 8 a.m. They indicated being disgusted when they searched through a dresser drawer for socks. They indicated clothing items such as socks were loose (not in pairs) in the drawers with other clothing "balled up" and thrown in the drawer. In the same drawer was an unclean razor, swabs and oral care items stored loose in the same drawer. 7. The Director of Nursing and			

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	Administrator were advised of this concern on 7/8/11 at the end of this observation tour. During interviews on 7/12/11, CNA #3 at 10:51 p.m. and CNA #4 at 1 p.m. individually asked what was the big deal about the drawers, who's job was it anyway, and commented they had never before been told to keep the drawers in order. CNA #4 commented, "I found a bacon sandwich in a drawer this morning." This federal tag relates to complaint number IN00092997. 3.1-18(b)(5)			